



EVALBRIEF: SYSTEMS OF CARE

November 2004

Volume 6, Issue 2

Launching the Primary Care Provider Study

Introduction

As early as 1978, primary care settings were collectively referred to as the *de facto* mental health system in the United States because of the widespread treatment of mental health problems within that venue (Regier, Goldberg, & Taube, 1978). The introduction of managed care in the early 70s, the subsequent proliferation of behavioral health carveouts, and the development of selective serotonin reuptake inhibitors have further increased the role of the primary care provider (PCP) as a screener for mental health problems, an initial contact into mental health services, and a provider of ongoing mental health services (Druss, 2002; Gray, Brody, & Hart, 2000).

Although PCPs play an important part in the delivery of mental health services, very little is known about the types of services PCPs provide, the quality of these services, and the outcomes for individuals with mental health problems treated within primary care. It would be useful for the Comprehensive Community Mental Health Services for Children and Their Families Program to have this and related information about PCPs, who play significant roles in the functioning of the program.

Study Overview

The Primary Care Provider Study was introduced for the fourth phase of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, which includes communities funded in 2002, 2003, and 2004. The Primary Care Provider Study is designed to investigate the role of PCPs in systems of care and to further understand the impact of services provided within primary care settings on child and family outcomes. More specifically, this study addresses four main questions:

Study Highlights

- ▶ *The Primary Care Provider Study is a three-part study designed to examine the role and impact of Primary Care Providers (PCPs) in systems of care.*
- ▶ *A steering committee comprised of community stakeholders (e.g., youth, caregivers, service providers, project directors, and PCPs) will help guide all aspects of the three-part study.*
- ▶ *The results of 10 focus groups conducted with system-of-care constituencies will be used to develop a model of factors influencing the role of PCPs in systems of care; the results will also be used to develop a Primary Care Provider Survey to be administered annually to 250 PCPs (i.e., 10 per Phase IV site, per year).*
- ▶ *Additional descriptive data about children's health status, care, and financing will be collected using the Enrollment and Demographic Information Form (EDIF) and the Caregiver Information Questionnaire (CIQ).*
- ▶ *Interim and final results of the Primary Care Provider Study will be disseminated as data become available throughout the course of the study.*

- ▶ What is the physical health status, health care utilization, and health care financing status of children with serious emotional disturbance participating in the program?
- ▶ How do the physical health status, health care utilization, and health care financing status of children with serious emotional disturbance vary over time and affect child and family outcomes?
- ▶ What factors influence PCPs' active participation in the care of children with serious emotional disturbance who are being served within systems of care?
- ▶ How does health care provided by PCPs influence child and family outcomes?

A key feature of this three-part study is that a steering committee comprised of community stakeholders will help guide all aspects of the study. Steering committee members represent such stakeholder groups as youth, caregivers, service providers, project directors, and PCPs. Members will provide input on study design and methodology, assist with data analysis and interpretation, and help develop dissemination materials for conference presentations and journal articles.

Methodology

Study Part 1

Part 1 of the study will utilize questionnaires to address these questions:

- ▶ What is the physical health status, health care utilization, and health care financing status of children participating in the program?
- ▶ How do these factors vary over time?
- ▶ How do these factors affect child and family outcomes?

This part of the study involves collecting descriptive data on participating children's health status, care, and financing through the Enrollment and Demographic Information Form (EDIF) and the Caregiver Information Questionnaire (CIQ).

Study Part 1 Data Collection Instruments

The EDIF is a Web-based questionnaire completed with all children who have received CMHS-supported services. Children enrolled in the Longitudinal Child and Family Outcome Study will complete a follow-up version of the EDIF, the Child Information Update Form (CIUF), every 6 months for 36 months.

Relevant data gathered from the EDIF and CIUF will include general medical conditions listed under the child's AXIS III *DSM-IV* diagnosis; who provided their diagnosis (e.g., psychologist, psychiatrist, PCP); and whether the child had private insurance or was a recipient of Medicaid, Children's Health Insurance Program, Supplemental Security Income, or Temporary Assistance for Needy Families. Data gathered via the EDIF will be analyzed regularly to provide descriptive statistics on such variables as the types of chronic physical health problems encountered by children in systems of care, who is providing their diagnoses, and how their care is funded.

The CIQ is administered to caregivers of children enrolled in the Longitudinal Child and Family Outcomes Study at intake and every 6 months for 36 months. The CIQ includes general questions about the child's physical health such as whether the child has a recurring or chronic physical health problem(s) and whether the child is taking medication related to the problem(s). The CIQ also contains questions about service utilization in the past 6 months such as

- ▶ how many times the child had to go to the emergency room,
- ▶ how many time the child was hospitalized, and
- ▶ whether s/he had to have a routine physical.

Study Part 2

Part 2, conducted during year 2 of the evaluation, will address the question, "What factors influence PCPs' active participation in the care of children who are being served within systems of care?" Group discussion will be the primary methodology for Study Part 2. Ten major themes that encompass the relationships between children's mental health, primary care services, and systems of care were

Table 1
10 Major Focus Group Themes

- ▶ The Role of PCPs in Prescribing Psychotropic Medication
- ▶ The Role of PCPs in Screening for Mental Health Disorders
- ▶ The Role of PCPs in Providing Ongoing Mental Health Care
- ▶ Integration of Primary Care Services and Systems of Care
- ▶ Financial Issues Related to Primary Care and Systems of Care
- ▶ Health Care Disparities in Systems of Care
- ▶ Family Active Participation in Primary Care
- ▶ Youth Active Participation in Primary Care
- ▶ Collaboration Between PCPs and Other Service Providers
- ▶ Programmatic Challenges to the Integration of Primary Care and Systems of Care

identified by steering committee members based upon the research literature and personal experience (see Table 1 for a list of the 10 themes). During the next step, the steering committee and ORC Macro staff will conduct 10 focus groups, two with each of the five stakeholder groups (youth, caregivers, service providers, project directors, and PCPs).

The 10 themes will be addressed throughout the groups. Some focus groups may address two or more themes, while other focus groups may address one or two themes. Focus group results will be used to develop a model of factors influencing the role of PCPs in systems of care and to develop a Primary Care Provider Survey to be administered during Part 3 of this study.

About Focus Groups

Focus groups are special-purpose groups that provide forums for structured discussion of a topic or topics, and are usually designed to elicit the opinions, attitudes, and beliefs of participants about an issue, product, event, or entity (Krueger, 1998). Focus groups are designed to examine the motivations of participants and learn how much they agree about the topic under discussion (Morgan, 1993).

As a type of qualitative data collection method, focus groups manifest both the advantages and

disadvantages associated with qualitative data analysis, identified in detail by Taleff (1999). On the plus side, qualitative methods allow for complexity in the data collection process. Focusing on “why?” and “how?” questions, they allow clients to reach and express their own conclusions and individual attitudes and beliefs. They emphasize interpretation and meaning of collected subjective data (often stemming from the use of open-ended responses) rather than the statistical description of data (Morgan, 1988). On the downside, focus groups, like other qualitative methods, do not allow the researcher to control the research process very well, often yield results that can be difficult to interpret and summarize, and are not easily analyzed using established statistical approaches (Simply Better! Continuous Improvement).

Common misconceptions about focus groups include the belief that they are cheap and quick, that they discourage discussion of sensitive topics, that professional facilitators must always serve as moderators, and that only strangers can participate (Morgan, 1993). Focus groups are not clinical groups. They are designed to elicit qualitative information, and are not for diagnostic or therapeutic purposes.

Despite these few methodological constraints, focus groups provide a convenient, relatively speedy, and intensive information-collecting method that can inform agency decision-makers about various programmatic issues. Qualitative information can be collected from numerous participant or target groups about many important programmatic issues.

The goal of focus groups—through the use of open-ended interviewing to explore and understand opinions and behaviors—is to maximize the divergence of opinions, rather than to bring participants to agreement about the topics of the discussion (Hawe, 1990). Focus groups provide in-depth insights and understanding of motivations, attitudes, and perceptions; can help generate new concepts, ideas, and questions; can help isolate key variables to use in quantitative research and surveys; and are relatively inexpensive, fast, and adaptable.

Study Part 3

Part 3 will be conducted during the remaining years of the evaluation and will address the question,

“How do health care services provided by primary care providers influence child and family outcomes?” PCPs will be asked to complete the Primary Care Provider Survey, which will contain mostly closed-ended questions. Providers can choose to respond via a Web-based survey, or a paper-and-pencil version of the survey. The targeted yearly sample total will be 250 primary care providers (i.e., 10 per Phase IV site, per year).

Current Status of the Study

Several project goals have been achieved. For example, potential candidates for steering committee positions were identified, screened, and interviewed within the opening months of the evaluation. Before the end of the first fiscal year, all five positions were filled. The committee was convened and over a 2-day period identified 10 focus group themes related to children’s mental health, primary care services, and systems of care.

Finally, at the end of November 2004, the EDIF was released after an extensive period of development and pilot testing, for communities to begin data collection. As noted above, data gathered via the EDIF will be used to answer questions related to Part 1 of the study.

Future Activities

For Part 2 of the study, six focus groups will be conducted during the Winter System of Care Community Meeting in Dallas, Texas, in early February 2005. Two groups will be conducted with caregivers, two with youth, one with project directors, and one with service providers. Additional

telephone focus groups will be conducted with PCPs, project directors, and service providers as needed.

Once the proposed 10 focus groups have been conducted, the content from these focus groups will be transcribed and analyzed to identify themes and subsequent questions for inclusion in the Primary Care Provider Survey. Survey development will begin shortly afterward, which will serve as the basis for Part 3 study activities. Interim and final results of the Primary Care Provider Study will be disseminated as data become available throughout the course of the study.

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